House of Representatives

General Assembly

File No. 583

January Session, 2015

Substitute House Bill No. 6856

House of Representatives, April 13, 2015

The Committee on Public Health reported through REP. RITTER of the 1st Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING SUBSTANCE ABUSE AND OPIOID OVERDOSE PREVENTION.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (b) of section 20-10b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(b) Except as otherwise provided in subsections (d), (e) and (f) of this section, a licensee applying for license renewal shall earn a minimum of fifty contact hours of continuing medical education within the preceding twenty-four-month period. Such continuing medical education shall (1) be in an area of the physician's practice; (2) reflect the professional needs of the licensee in order to meet the health care needs of the public; and (3) during the first renewal period in which continuing medical education is required and not less than once every six years thereafter, include at least one contact hour of training or education in each of the following topics: (A) Infectious diseases, including, but not limited to, acquired immune deficiency syndrome

and human immunodeficiency virus, (B) risk management, including, but not limited to, for registration periods beginning on or after October 1, 2015, prescribing controlled substances and pain management, (C) sexual assault, (D) domestic violence, (E) cultural competency, and (F) behavioral health. For purposes of this section, qualifying continuing medical education activities include, but are not limited to, courses offered or approved by the American Medical Association, American Osteopathic Medical Association, Connecticut Hospital Association, Connecticut State Medical Society, county medical societies or equivalent organizations in another jurisdiction, educational offerings sponsored by a hospital or other health care institution or courses offered by a regionally accredited academic institution or a state or local health department. The commissioner, or the commissioner's designee, may grant a waiver for not more than ten contact hours of continuing medical education for a physician who: (i) Engages in activities related to the physician's service as a member of the Connecticut Medical Examining Board, established pursuant to section 20-8a; (ii) engages in activities related to the physician's service as a member of a medical hearing panel, pursuant to section 20-8a; or (iii) assists the department with its duties to boards and commissions as described in section 19a-14.

Sec. 2. Subsection (b) of section 20-94d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(b) Except as provided in this section, for registration periods beginning on and after October 1, 2014, a licensee applying for license renewal shall earn a minimum of fifty contact hours of continuing education within the preceding twenty-four-month period. Such continuing education shall: (1) Be in an area of the advanced practice registered nurse's practice; (2) reflect the professional needs of the licensee in order to meet the health care needs of the public; (3) include at least five contact hours of training or education in pharmacotherapeutics; and (4) include at least one contact hour of training or education in each of the following topics: (A) Infectious

diseases, including, but not limited to, acquired immune deficiency syndrome and human immunodeficiency virus, (B) risk management, including, but not limited to, prescribing controlled substances and pain management, (C) sexual assault, (D) domestic violence, (E) cultural competency, and (F) substance abuse. For purposes of this section, qualifying continuing education activities include, but are not limited to, courses, including on-line courses, offered or approved by the American Nurses Association, Connecticut Hospital Association, Connecticut Nurses Association, Connecticut League for Nursing, a specialty nursing society or an equivalent organization in another jurisdiction, an educational offering sponsored by a hospital or other health care institution or a course offered by a regionally accredited academic institution or a state or local health department. The commissioner may grant a waiver of not more than ten contact hours of continuing education for an advanced practice registered nurse who: (i) Engages in activities related to the advanced practice registered nurse's service as a member of the Connecticut State Board of Examiners for Nursing, established pursuant to section 20-88; or (ii) assists the department with its duties to boards and commissions as described in section 19a-14.

Sec. 3. Subsection (b) of section 20-126c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(b) Except as otherwise provided in this section, a licensee applying for license renewal shall earn a minimum of twenty-five contact hours of continuing education within the preceding twenty-four-month period. Such continuing education shall (1) be in an area of the licensee's practice; (2) reflect the professional needs of the licensee in order to meet the health care needs of the public; and (3) include not less than one contact hour of training or education in (A) any **[**five**]** four of the ten mandatory topics for continuing education activities prescribed by the commissioner pursuant to this subdivision, and (B) prescribing controlled substances and pain management. For registration periods beginning on and after October 1, 2011, the

Commissioner of Public Health, in consultation with the Dental Commission, shall on or before October 1, 2010, and biennially thereafter, issue a list that includes ten mandatory topics for continuing education activities that will be required for the following two-year registration period. Qualifying continuing education activities include, but are not limited to, courses, including on-line courses, offered or approved by the American Dental Association or state, district or local dental associations and societies affiliated with the American Dental Association; national, state, district or local dental specialty organizations or the American Academy of General Dentistry; a hospital or other health care institution; dental schools and other schools of higher education accredited or recognized by the Council on Dental Accreditation or a regional accrediting organization; agencies or businesses whose programs are accredited or recognized by the Council on Dental Accreditation; local, state or national medical associations; a state or local health department; or the Accreditation Council for Graduate Medical Education. Eight hours of volunteer dental practice at a public health facility, as defined in section 20-126*l*, may be substituted for one contact hour of continuing education, up to a maximum of ten contact hours in one twenty-four-month period.

Sec. 4. Subdivision (6) of subsection (c) of section 19a-88 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(6) Each person holding a license as a physician assistant shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of a fee of one hundred fifty dollars, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. No such license shall be renewed unless the department is satisfied that the practitioner (A) has met the mandatory continuing medical education requirements of the National Commission on Certification of Physician Assistants or a successor organization for the certification or recertification of physician assistants that may be

approved by the department, **[**and**]** (B) has passed any examination or continued competency assessment the passage of which may be required by said commission for maintenance of current certification by said commission, and (C) has completed not less than one contact hour of training or education in prescribing controlled substances and pain management in the preceding two-year period.

Sec. 5. Subsection (j) of section 21a-254 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(j) (1) The commissioner shall, within available appropriations, establish an electronic prescription drug monitoring program to collect, by electronic means, prescription information for schedules II, III, IV and V controlled substances **[**, as defined in subdivision (9) of section 21a-240,**]** that are dispensed by pharmacies, nonresident pharmacies, as defined in section 20-627, outpatient pharmacies in hospitals or institutions or by any other dispenser. **[**, as defined in section 21a-240.**]** The program shall be designed to provide information regarding the prescription of controlled substances in order to prevent the improper or illegal use of the controlled substances and shall not infringe on the legitimate prescribing of a controlled substance by a prescribing practitioner acting in good faith and in the course of professional practice.

(2) The commissioner may identify other products or substances to be included in the electronic prescription drug monitoring program established pursuant to subdivision (1) of this subsection.

(3) **[**Each**]** Prior to July 1, 2016, each pharmacy, nonresident pharmacy, as defined in section 20-627, outpatient pharmacy in a hospital or institution and dispenser **[**, as defined in section 21a-240,**]** shall report to the commissioner, at least weekly, by electronic means or, if a pharmacy or outpatient pharmacy does not maintain records electronically, in a format approved by the commissioner, the following information for all controlled substance prescriptions dispensed by such pharmacy or outpatient pharmacy: (A) Dispenser

identification number; (B) the date the prescription for the controlled substance was filled; (C) the prescription number; (D) whether the prescription for the controlled substance is new or a refill; (E) the national drug code number for the drug dispensed; (F) the amount of the controlled substance dispensed and the number of days' supply of the controlled substance; (G) a patient identification number; (H) the patient's first name, last name and street address, including postal code; (I) the date of birth of the patient; (J) the date the prescription for the controlled substance was issued by the prescribing practitioner and the prescribing practitioner's Drug Enforcement Agency's identification number; and (K) the type of payment.

(4) On and after July 1, 2016, each pharmacy, nonresident pharmacy, as defined in section 20-627, outpatient pharmacy in a hospital or institution, and dispenser shall report to the commissioner by electronic means, in a format approved by the commissioner, the following information for all controlled substance prescriptions dispensed by such pharmacy or outpatient pharmacy immediately upon dispensing such prescriptions: (A) Dispenser identification number; (B) the date the prescription for the controlled substance was filled; (C) the prescription number; (D) whether the prescription for the controlled substance is new or a refill; (E) the national drug code number for the drug dispensed; (F) the amount of the controlled substance dispensed and the number of days' supply of the controlled substance; (G) a patient identification number; (H) the patient's first name, last name and street address, including postal code; (I) the date of birth of the patient; (J) the date the prescription for the controlled substance was issued by the prescribing practitioner and the prescribing practitioner's Drug Enforcement Agency's identification number; and (K) the type of payment.

[(4)**]** (5) The commissioner may contract with a vendor for purposes of electronically collecting such controlled substance prescription information. The commissioner and any such vendor shall maintain the information in accordance with the provisions of chapter 400j.

[(5)**]** (6) The commissioner and any such vendor shall not disclose controlled substance prescription information reported pursuant to **[**subdivision (3)**]** subdivisions (3) and (4) of this subsection, except as authorized pursuant to the provisions of sections 21a-240 to 21a-283, inclusive. Any person who knowingly violates any provision of this subdivision or subdivision **[**(4)**]** (5) of this subsection shall be guilty of a class D felony.

[(6)**]** (7) The commissioner shall provide, upon request, controlled substance prescription information obtained in accordance with **[**subdivision (3)**]** subdivisions (3) and (4) of this subsection to the following: (A) The prescribing practitioner, or such practitioner's authorized agent who is also a licensed health care professional, who is treating or has treated a specific patient, provided the information is obtained for purposes related to the treatment of the patient, including the monitoring of controlled substances obtained by the patient; (B) the prescribing practitioner with whom a patient has made contact for the purpose of seeking medical treatment, provided the request is accompanied by a written consent, signed by the prospective patient, for the release of controlled substance prescription information; or (C) the pharmacist who is dispensing controlled substances for a patient, provided the information is obtained for purposes related to the scope of the pharmacist's practice and management of the patient's drug therapy, including the monitoring of controlled substances obtained by the patient. The prescribing practitioner, such practitioner's authorized agent, or the pharmacist shall submit a written and signed request to the commissioner for controlled substance prescription information. Such prescribing practitioner or pharmacist shall not disclose any such request except as authorized pursuant to sections 20-570 to 20-630, inclusive, or sections 21a-240 to 21a-283, inclusive.

[(7)**]** (8) No person or employer shall prohibit, discourage or impede a prescribing practitioner or pharmacist from requesting controlled substance prescription information pursuant to this subsection.

(9) Prior to prescribing greater than a seventy-two-hour supply of

any controlled substance to any patient, the prescribing practitioner or such practitioner's authorized agent who is also a licensed health care professional shall review the patient's records in the electronic prescription drug monitoring program established pursuant to this subsection. Whenever a prescribing practitioner prescribes controlled substances for the continuous or prolonged treatment of any patient, such prescriber, or such prescriber's authorized agent who is also a licensed health care professional, shall review, not less than once every ninety days, the patient's records in such prescription drug monitoring program.

[(8)**]** (10) The commissioner shall adopt regulations, in accordance with chapter 54, concerning the reporting, evaluation, management and storage of electronic controlled substance prescription information.

[(9)**]** (11) The provisions of this section shall not apply to (A) samples of controlled substances dispensed by a physician to a patient, or (B) any controlled substances dispensed to hospital inpatients.

[(10)**]** (12) The provisions of this section shall not apply to any institutional pharmacy or pharmacist's drug room operated by a facility, licensed under section 19a-495 and regulations adopted pursuant to said section 19a-495, that dispenses or administers directly to a patient an opioid **[**antagonists**]** agonist for treatment of a substance use disorder.

Sec. 6. (NEW) (*Effective from passage*) (a) A person who is licensed as a pharmacist under part II of chapter 400j of the general statutes and is certified in accordance with subsection (b) of this section may prescribe, in good faith, an opioid antagonist, as defined in section 17a-714a of the general statutes, as amended by this act. Such pharmacist shall (1) provide appropriate training regarding the administration of such opioid antagonist to the person to whom the opioid antagonist is dispensed, and (2) maintain a record of such dispensing and the training required pursuant to chapter 400j of the general statutes.

(b) A pharmacist may only prescribe an opioid antagonist pursuant to this section if the pharmacist has been trained and certified by a program approved by the Commissioner of Consumer Protection.

(c) A pharmacist who prescribes an opioid antagonist in compliance with this section shall be deemed not to have violated any standard of care for a pharmacist.

(d) The provisions of this section shall apply only to a pharmacist certified in accordance with subsection (b) of this section. No pharmacist may delegate or direct any other person to prescribe an opioid antagonist or train any person in the administration of such opioid antagonist pursuant to the provisions of subsection (a) of this section.

(e) The Commissioner of Consumer Protection may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 7. Subdivision (1) of section 38a-175 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(1) "Healing arts" means the professions and occupations licensed under the provisions of chapters 370, 372, 373, 375, 378, 379, 380, 381, **[**and**]** 383 and 400j.

Sec. 8. Section 17a-714a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For purposes of this section, "opioid antagonist" means naloxone hydrochloride or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of drug overdose.

(b) A licensed health care professional who is permitted by law to prescribe an opioid antagonist may **[**, if acting with reasonable care,**]** prescribe, dispense or administer an opioid antagonist to any

individual to treat or prevent a drug overdose without being liable for damages in a civil action or subject to criminal prosecution for prescribing, dispensing or administering such opioid antagonist or for any subsequent use of such opioid antagonist. A licensed health care professional who prescribes, dispenses or administers an opioid antagonist in accordance with the provisions of this subsection shall be deemed not to have violated the standard of care for such licensed health care professional.

(c) Any person, who in good faith believes that another person is experiencing an opioid-related drug overdose may, if acting with reasonable care, administer an opioid antagonist to such other person. Any person, other than a licensed health care professional acting in the ordinary course of such person's employment, who administers an opioid antagonist in accordance with this subsection shall not be liable for damages in a civil action or subject to criminal prosecution with respect to the administration of such opioid antagonist.

Sec. 9. Section 17a-667 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is established a Connecticut Alcohol and Drug Policy Council which shall be within the **[**Office of Policy and Management for administrative purposes only**]** Department of Mental Health and Addiction Services.

(b) The council shall consist of the following members: (1) The Secretary of the Office of Policy and Management, or the secretary's designee; (2) the Commissioners of Children and Families, Consumer Protection, Correction, Education, **[**Higher Education,**]** Mental Health and Addiction Services, **[**Motor Vehicles,**]** Public Health, Emergency Services and Public Protection **[**,**]** and Social Services, **[**and Transportation**]** Commissioner on Aging, and the Insurance Commissioner, or their designees; (3) the Chief Court Administrator, or the Chief Court Administrator's designee; (4) the chairperson of the Board of **[**Pardons and Paroles**]** Regents for Higher Education, or the chairperson's designee; (5) the president of The University of

Connecticut, or the president's designee; (6) the Chief State's Attorney, or the Chief State's Attorney's designee; **[**(6)**]** (7) the Chief Public Defender, or the Chief Public Defender's designee; and **[**(7)**]** (8) the cochairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to public health, criminal justice and appropriations, or their designees. The Commissioner of Mental Health and Addiction Services and the Commissioner of Children and Families shall be cochairpersons of the council and may jointly appoint up to six individuals to the council as follows: (A) Two individuals in recovery from a substance use disorder or representing an advocacy group for individuals with a substance use disorder; (B) a provider of community-based substance abuse services for adults; (C) a provider of community-based substance abuse services for adolescents; (D) an addiction medicine physician; and (E) a family member of an individual in recovery from a substance use disorder. **[**The Office of Policy and Management shall, within available appropriations, provide staff for the council.**]**

(c) The council shall review policies and practices of state agencies and the Judicial Department concerning substance abuse treatment programs, substance abuse prevention services, the referral of persons to such programs and services, and criminal justice sanctions and programs and shall develop and coordinate a state-wide, interagency, integrated plan for such programs and services and criminal sanctions.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2015*	20-10b(b)
Sec. 2	*October 1, 2015*	20-94d(b)
Sec. 3	*October 1, 2015*	20-126c(b)
Sec. 4	*October 1, 2015*	19a-88(c)(6)
Sec. 5	*October 1, 2015*	21a-254(j)
Sec. 6	*from passage*	New section
Sec. 7	*from passage*	38a-175(1)
Sec. 8	*from passage*	17a-714a
Sec. 9	*from passage*	17a-667

PH *Joint Favorable Subst.*

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 16 $	FY 17 $
Consumer Protection, Dept.	GF - Cost	187,511	187,511
Comptroller Misc. Accounts (Fringe Benefits)[1]	GF - Cost	18,363	18,363
Consumer Protection, Dept.	GOBonds - Cost	126,000	None

Note: GF=General Fund; GOBonds=General Obligation Bonds

Municipal Impact: None

Explanation

The bill results in a cost to the state in FY 16 of $331,874 and $205,874 in FY 17. The cost in FY 16 includes $47,511 for a Health Program Assistant to administer the increased usage and reporting required in the bill through the Prescription Monitoring Program (PMP), fringe benefits of $18,363 and $140,000 in Other Expenses for operating costs of the PMP. Additional one-time costs of $126,000 are required for upgrades to the PMP as follows: clinical notification ($27,500), excessive lookup alert ($10,500), case management ($22,000) and Mobile Device App ($66,000). Costs in FY 17 continue for the personnel and the operating expenses. HB 6824, An Act Concerning the State Budget for the Biennium Ending June Thirtieth 2017, and Making Appropriations Therefor and Other Provisions Related to Revenue contains funding for the program.

The Out Years

The annualized ongoing fiscal impact identified above to the

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 38.65% of payroll in FY 16 and FY 17.

General Fund would continue into the future subject to inflation.

OLR Bill Analysis

sHB 6856

AN ACT CONCERNING SUBSTANCE ABUSE AND OPIOID OVERDOSE PREVENTION.

SUMMARY:

This bill makes various changes affecting prescription drugs, drug abuse prevention, and related topics. Among other things, it:

1. requires practitioners, before prescribing greater than a 72-hour supply of any controlled substance, to check the patient's record in the prescription drug monitoring program;

2. requires practitioners to review the patient's record at least every 90 days if prescribing for prolonged treatment;

3. starting in July 2016, requires pharmacists to immediately report to the monitoring program on prescriptions they fill, rather than at least weekly, and requires the reporting to be done electronically;

4. makes other changes to the prescription drug monitoring program, including exempting opioid agonists in certain situations;

5. allows pharmacists to prescribe opioid antagonists, used to treat drug overdoses, if they receive special training and certification to do so, and expands the existing immunity for all prescribers when prescribing, dispensing, or administering opioid antagonists;

6. requires physicians, advanced practice registered nurses (APRNs), dentists, and physician assistants (PAs) to take continuing education in prescribing controlled substances and

pain management;

7. makes changes to membership and other matters concerning the Connecticut Alcohol and Drug Policy Council; and

8. adds pharmacists to the definition of "healing arts" in the health care center (HMO) statutes.

The bill also makes technical and conforming changes.

EFFECTIVE DATE: Upon passage, except the provisions on continuing education and the prescription drug monitoring program are effective October 1, 2015.

§ 5 – ELECTRONIC PRESCRIPTION DRUG MONITORING PROGRAM

Requirements for Prescribers

Under the prescription drug monitoring program, the Department of Consumer Protection (DCP) collects information on controlled substance prescriptions to prevent improper or illegal drug use or improper prescribing.

Under the bill, before prescribing more than a 72-hour supply of a controlled substance, the practitioner or his or her authorized agent, who is also a licensed health care professional, must review the patient's records in the prescription drug monitoring program.

The bill also requires a prescribing practitioner or agent to review a patient's records in the program at least every 90 days when the practitioner prescribes controlled substances for continuous or prolonged treatment.

By law, various health care professionals are authorized to prescribe controlled substances, including physicians, APRNs, dentists, nurse-midwives, optometrists, PAs, podiatrists, and veterinarians.

Prescription Reporting

By law, pharmacists and other controlled substance dispensers must

generally report certain prescription information to DCP under the program, such as the dispensing date, dispenser identification and prescription number, and patient identifying information.

Starting July 1, 2016, the bill requires them to report to the program immediately after dispensing controlled substances, instead of at least weekly. It also requires the information to be submitted electronically according to a DCP-approved format. Current law allows other DCP-approved methods of reporting by pharmacies or outpatient pharmacies, if they do not maintain electronic records.

As under existing law, these reporting requirements apply to (1) pharmacies; (2) nonresident pharmacies (i.e., out-of-state pharmacies that send prescription drugs into the state); (3) outpatient pharmacies in hospitals or institutions; and (4) practitioners who dispense controlled substances.

Existing law requires the DCP commissioner to release the information, on written request, to certain people, including a prescribing practitioner who is treating or has treated a specific patient, if the information is for treatment purposes (including drug monitoring). The bill also requires the commissioner to release the information to such a practitioner's authorized agent who is also a licensed health care professional.

Current law exempts from the program's reporting requirements institutional pharmacies or pharmacists' drug rooms operated by licensed institutions, when dispensing or administering opioid antagonists to patients to treat a substance use disorder. The bill removes this exemption and instead applies the exemption to opioid agonists.

Opioid agonists are medications such as morphine that activate the same areas of the brain as other opioids. Opioid antagonists block the effect of opioids and are often used to treat drug overdoses (see below).

§§ 6 & 8 – OPIOID ANTAGONISTS

Prescriptive Authority for Pharmacists

Under certain conditions, the bill allows licensed pharmacists to prescribe opioid antagonists. To do so, the pharmacist must (1) have been trained and certified by a program approved by the DCP commissioner and (2) act in good faith.

Under the bill, when such a pharmacist dispenses an opioid antagonist, he or she must provide training to the person on how to administer it. The pharmacist must also maintain a record of the dispensing and training under the law's recordkeeping requirements. The bill prohibits a pharmacist from delegating to or directing another person to prescribe an opioid antagonist or provide this training.

The bill specifies that a pharmacist who prescribes an opioid antagonist and meets these requirements is not deemed to have violated any standard of care for pharmacists (see below on immunity from liability).

The DCP commissioner may adopt implementing regulations.

By law, an "opioid antagonist" is naloxone hydrochloride (e.g., Narcan) or any other similarly acting and equally safe drug that the Food and Drug Administration has approved for treating a drug overdose.

Immunity from Liability

The bill expands the current civil and criminal immunity for licensed health care professionals authorized to prescribe an opioid antagonist, when prescribing, dispensing, or administering it to treat or prevent a drug overdose. (The immunity applies to these actions or the subsequent use of the antagonist.)

The bill removes the condition that the immunity applies only if the professional acts with reasonable care. It also makes a technical change to clarify that these professionals may prescribe, dispense, or administer the antagonist to any individual.

The bill also specifies that a professional who prescribes, dispenses, or administers an opioid antagonist in accordance with these provisions is deemed not to have violated the applicable standard of care.

§§ 1-4 – CONTINUING EDUCATION

The bill requires physicians, APRNs, dentists, and PAs to take continuing education in prescribing controlled substances and pain management, as follows.

For physicians and APRNs, this applies as part of the existing requirement that they complete continuing education in risk management. By law, physicians must take at least one contact hour (i.e., at least 50 minutes of continuing education) of risk management training or education (1) during their first renewal period in which continuing education is required and (2) at least once every six years after that. APRNs must take at least one such contact hour every two years. (Both physicians and APRNs generally must complete 50 hours of continuing education every two years, starting with their second license renewal.)

The bill specifies that the new requirement applies to physicians for registration periods beginning on or after October 1, 2015.

For dentists, the bill requires at least one contact hour every two years of training or education in prescribing controlled substances and pain management. The bill makes a corresponding change by providing that dentists' other continuing education must include at least one contact hour in any four, rather than five, of the 10 mandatory topics prescribed by the public health commissioner. (Dentists generally must complete 25 hours of continuing education every two years, starting with their second license renewal.)

For PAs, the bill requires at least one contact hour every two years of training or education in prescribing controlled substances and pain management. (By law, to renew their licenses, PAs must have completed the mandatory continuing education requirements needed

to maintain national certification.)

§ 9 – ALCOHOL AND DRUG POLICY COUNCIL

By law, the Connecticut Alcohol and Drug Policy Council is charged with (1) reviewing state policies on substance abuse treatment programs and criminal sanctions and programs and (2) developing and coordinating a statewide plan for these matters.

Currently, the council is within the Office of Policy and Management (OPM) for administrative purposes only. The bill transfers the council to the Department of Mental Health and Addiction Services (DMHAS) for these same purposes. It eliminates the requirement that OPM, within available appropriations, provide staff for the council.

The bill also makes several changes to the council's membership. It adds to the council the aging commissioner, chairperson of the board of regents for higher education, and UConn president, or their designees. It removes as members the higher education, motor vehicles, and transportation commissioners and the chairperson of the board of pardons and paroles, or their designees. (The higher education commissioner position was eliminated in 2011.)

The bill also allows the council's co-chairpersons, the DMHAS and children and families commissioners, to jointly appoint up to six members, including:

1. two people in recovery from a substance use disorder or who represent an advocacy group for people with these disorders,
2. a provider of community-based substance abuse services for adults,
3. a provider of these services for adolescents,
4. an addiction medicine physician, and
5. a family member of someone in recovery.

§ 7 – HEALING ARTS IN HMO STATUTES

The bill adds pharmacists to the definition of "healing arts" in the HMO statutes. Various provisions in the HMO statutes refer to healing arts, including provisions on:

1. training provided under the direction of people licensed to practice a healing art (CGS §§ 38a-176 and -177),

2. required representation for healing arts practitioners on the boards of HMOs organized as corporations (CGS § 38a-179), and

3. allowing (a) healing arts practitioners to be employed by and participate in HMOs and (b) patients to choose healing arts practitioners in the HMO (CGS § 38a-180).

Pharmacists are not included in the more general statutory definition of healing arts (CGS § 20-1).

BACKGROUND

Related Bill

sSB 28 (File No. 329), reported favorably by the General Law Committee, bars the DCP commissioner from issuing or renewing a license of a practitioner who distributes, administers, or dispenses controlled substances if the practitioner failed to register for access to the electronic prescription drug monitoring program, as existing law requires.

HB 5782, reported favorably by the General Law and Public Health committees, authorizes pharmacists to dispense and administer opioid antagonists if they receive training and certification to do so. It also makes changes concerning immunity for providers, including specifying that a licensed professional who prescribes, dispenses, or administers an opioid antagonist in accordance with the law is deemed not to have violated the applicable standard of care.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 27 Nay 0 (03/25/2015)